

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 115C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01137

Dr. Gilmore

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 1006 Bell Ave.			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) GORDON WILLIAM ADKINS				4. DATE OF DEATH (Month) (Day) (Year) Jan. 5th 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 24, 1920		9. AGE last birthday 35 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Concrete Co.		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gordon Adkins				14. MOTHER'S MAIDEN NAME Laura Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Mary Jean Adkins (Wife) 1006 Bell Ave. Salisbury, Maryland			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Uremia				1 1/2 yrs			
ANTECEDENT CAUSE(S) DUE TO (B) Intracapillary Glomerulosclerosis				3 "			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Diabetes Mellitus				Unknown			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Myocardial Insufficiency				6 months			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 3-5 , 19 56 , to 1/5 , 19 56 , that I last saw the deceased alive on Jan 3-5 , 19 56 , and that death occurred at 10:08 AM , from the causes and on the date stated above.							
SIGNATURE David J. Selmon				ADDRESS (Street, city, town, state) Medical Center Salisbury, Maryland			
DATE SIGNED 6/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 8, 1956		NAME OF CEMETERY OR CREMATORY Episcopal Cemetery		LOCATION (City, town, or county) (State) Princess Anne, Maryland	
24. REC'D BY REGISTRAR 11 1956		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

BUREAU V. S.

JAN 11 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1161

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Somerset</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>one month</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Crisfield</u>	<u>19-39-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Riverside Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Maryland Ave.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>IRENE</u>	(Middle) <u>WARD</u>	(Last) <u>ATKINSON</u>	OF DEATH: <u>January 1 1956</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>August 16, 1879</u>
9. AGE last birthday <u>76</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Crisfield, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Augustus Ward</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>11/18</u> , 19 <u>55</u> , to <u>1/1/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1</u> , 19 <u>56</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Thomas C. Hill, Jr.</u>		ADDRESS <u>M.O. 224 N. Division Street</u>	
DATE SIGNED <u>1/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 4, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Sunnyridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-7-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Hollonay</u>	
24. FUNERAL DIRECTOR <u>Bradshaw & Sons—Crisfield, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 10 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01139

Reg. Dist. No.

1162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		STATE <u>MARYLAND</u>		CITY <u>SALISBURY</u>		COUNTY <u>WICOMICO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY <u>WICOMICO</u>	
OR TOWN <u>SALISBURY</u>		<u>2 days</u>		OR TOWN <u>SALISBURY</u>		<u>12</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>308 BOWLING LANE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>CHESTER</u> (First) <u>BIVENS</u> (Last)				<u>JANUARY 31</u> (Month) <u>1956</u> (Year)			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>M</u>		<u>COLORED</u>		<u>MARRIED</u>		<u>1888</u>	
9. AGE last birthday		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>68</u> yrs.		<u>LABORER</u>		<u>PARSONSBURG, MARYLAND</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>JOHN BIVENS</u>				<u>ROSA PORTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>				<u>217-10-2265</u>		<u>308 BOWLING LANE</u>	
18. MEDICAL CERTIFICATION				19. DATE OF OPERATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>Indefinite</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>21 Jan, 1956</u> to <u>31 Jan, 1956</u>, that I last saw the deceased alive on <u>31 Jan, 1956</u>, and that death occurred at <u>5:45</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Starnell, M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Md</u>		DATE SIGNED <u>2 Feb 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>				<u>GREEN ACRES MEM. PARK</u>		<u>SALISBURY, WICOMICO Co. MD</u>	
24. REC'D BY REGISTRAR				25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 6 1956</u>				<u>Mary H. Holloway</u>		<u>Mary A. Stewart</u>	
DATE				REGISTRAR'S SIGNATURE		ADDRESS	
				<u>Salisbury, Md.</u>		<u>Funeral Home, Salisbury, Md.</u>	

CERTIFICATE OF DEATH

1918

DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. S.

RECEIVED

1918

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1163

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		STATE <u>MARYLAND</u>		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>15 days.</u>		TOWN <u>BERLIN</u>		<u>232-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>RT. 2</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>DAISEY</u> (Middle) <u>ANN</u> (Last) <u>BOWEN</u>				<u>JANUARY 10 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Apr. 26 1893</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Berlin, Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas W. Hastings</u>				14. MOTHER'S MAIDEN NAME <u>Annie K. Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Leon Massey, Berlin, Md</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>422-2 Degenerative heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-27</u> , 19 <u>55</u> , to <u>1-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-9</u> , 19 <u>56</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Ellis, Jr.</u> M.D. <u>Salisbury, Md.</u>				DATE SIGNED <u>1-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Berlin, Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Hallaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>		ADDRESS <u>Berlin, Md.</u>	
DATE <u>1/19/56</u>							

CERTIFICATE OF DEATH

1189

Year 1914

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Nature of disease

10. Duration of disease

11. Name of physician

12. Name of funeral director

13. Name of undertaker

14. Name of cemetery

15. Name of place of interment

16. Name of place of burial

17. Name of place of cremation

18. Name of place of entombment

19. Name of place of inhumation

20. Name of place of deposition

21. Name of place of disposal

22. Name of place of removal

23. Name of place of transportation

24. Name of place of conveyance

25. Name of place of delivery

26. Name of place of presentation

27. Name of place of production

28. Name of place of preparation

29. Name of place of preservation

30. Name of place of protection

31. Name of place of promotion

32. Name of place of prohibition

33. Name of place of prohibition

34. Name of place of prohibition

35. Name of place of prohibition

36. Name of place of prohibition

37. Name of place of prohibition

38. Name of place of prohibition

39. Name of place of prohibition

40. Name of place of prohibition

41. Name of place of prohibition

42. Name of place of prohibition

43. Name of place of prohibition

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other person who has attended the deceased, or by the funeral director or undertaker, or by the person who has taken charge of the body of the deceased after death.

2. The name of the deceased should be written in full, and the name of the place of birth should be written in full.

3. The date of death should be written in full, and the place of death should be written in full.

4. The cause of death should be written in full, and the nature of the disease should be written in full.

5. The duration of the disease should be written in full, and the name of the physician should be written in full.

6. The name of the funeral director should be written in full, and the name of the undertaker should be written in full.

7. The name of the cemetery should be written in full, and the name of the place of interment should be written in full.

8. The name of the place of burial should be written in full, and the name of the place of cremation should be written in full.

9. The name of the place of entombment should be written in full, and the name of the place of inhumation should be written in full.

10. The name of the place of deposition should be written in full, and the name of the place of disposal should be written in full.

11. The name of the place of removal should be written in full, and the name of the place of transportation should be written in full.

12. The name of the place of conveyance should be written in full, and the name of the place of delivery should be written in full.

13. The name of the place of presentation should be written in full, and the name of the place of production should be written in full.

14. The name of the place of preparation should be written in full, and the name of the place of preservation should be written in full.

15. The name of the place of protection should be written in full, and the name of the place of promotion should be written in full.

16. The name of the place of prohibition should be written in full, and the name of the place of prohibition should be written in full.

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BUREAU V. 2

JAN 13 1914

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1164

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 332

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Accomack</u>	MARYLAND	STATE <u>Pa</u>	COUNTY <u>Worcester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) <u>Keenal - Fourness</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>John Taylor Farm</u>	
3. NAME OF DECEASED:	(First) (Middle) (Last)	4. DATE OF DEATH	(Month) (Day) (Year)
<u>Birth</u>	<u>Brutington</u>	<u>Jan 31</u>	<u>1956</u>
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>5</u>	8. DATE OF BIRTH: <u>Aug 28/57</u>
9. AGE last birthday: <u>3</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Child</u>	11. BIRTHPLACE (State or foreign country): <u>Keenal City, Pa</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME: <u>Alexander Brutington</u>	14. MOTHER'S MAIDEN NAME: <u>Rosema Jones</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS: <u>Alexander Brutington (father)</u>	18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Shock</u>		<u>15 days</u>	
Antecedent cause(s) (b) <u>Burns (80% of body) (3rd degree)</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>skin grafting on day of death</u>			
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH	21b. PLACE (Home, farm, factory, street, office bldg., etc., INJURY) <u>Home</u>	21c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21d. HOW DID INJURY OCCUR? <u>Child caught fire from a wood stove</u>
21d. TIME (Month) (Day) (Year) <u>Jan 16 '56 PM</u>	22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>J. E. Sartorius</u>	CHIEF MEDICAL EXAMINER	DEPUTY MEDICAL EXAMINER	DATE SIGNED <u>1/31/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/5/56</u>	NAME OF CEMETERY OR CREMATORY <u>St Lawrence</u>	LOCATION (City, town, or county) (State) <u>Accomack, Md.</u>
DATE REC'D BY LOCAL REG <u>2-10-56</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. HEALTH DIRECTOR <u>B. Edgar Wharton</u>	ADDRESS <u>New Church, Va.</u>

RECEIVED

JUN 14 1956

BUREAU V. S.

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01141

Reg. Dist. No. 332

Dr. Beardsley

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE Maryland		COUNTY Wicomico			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) 210 Clay St.			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARY (Middle) ELLEN (Last) BROWN				(Month) JAN. (Day) 16 (Year) 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Aug. 16, 1905	9. AGE last birthday 50 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months 5	Days 0	Hours 0	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Operator)				10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory		11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME XX Arthur Shockley				14. MOTHER'S MAIDEN NAME Alice Davis			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. W. Randolph Brown (Husband) 210 Clay St. Salisbury, Maryland	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 331X				INTERVAL BETWEEN ONSET AND DEATH 8 hrs.			
ANTECEDENT CAUSE(S) DUE TO (B) Essential hypertension				3 yrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 19 55 to 1-16 56 , that I last saw the deceased alive on 1-16 56 , and that death occurred at 3:45 P.M. from the causes and on the date stated above.							
SIGNATURE Dr. Beardsley		M.D. Salisbury, Md		ADDRESS (Street, city, town, state)		DATE SIGNED 1/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 18, 1956		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

U.S. BUREAU

JAN 18



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

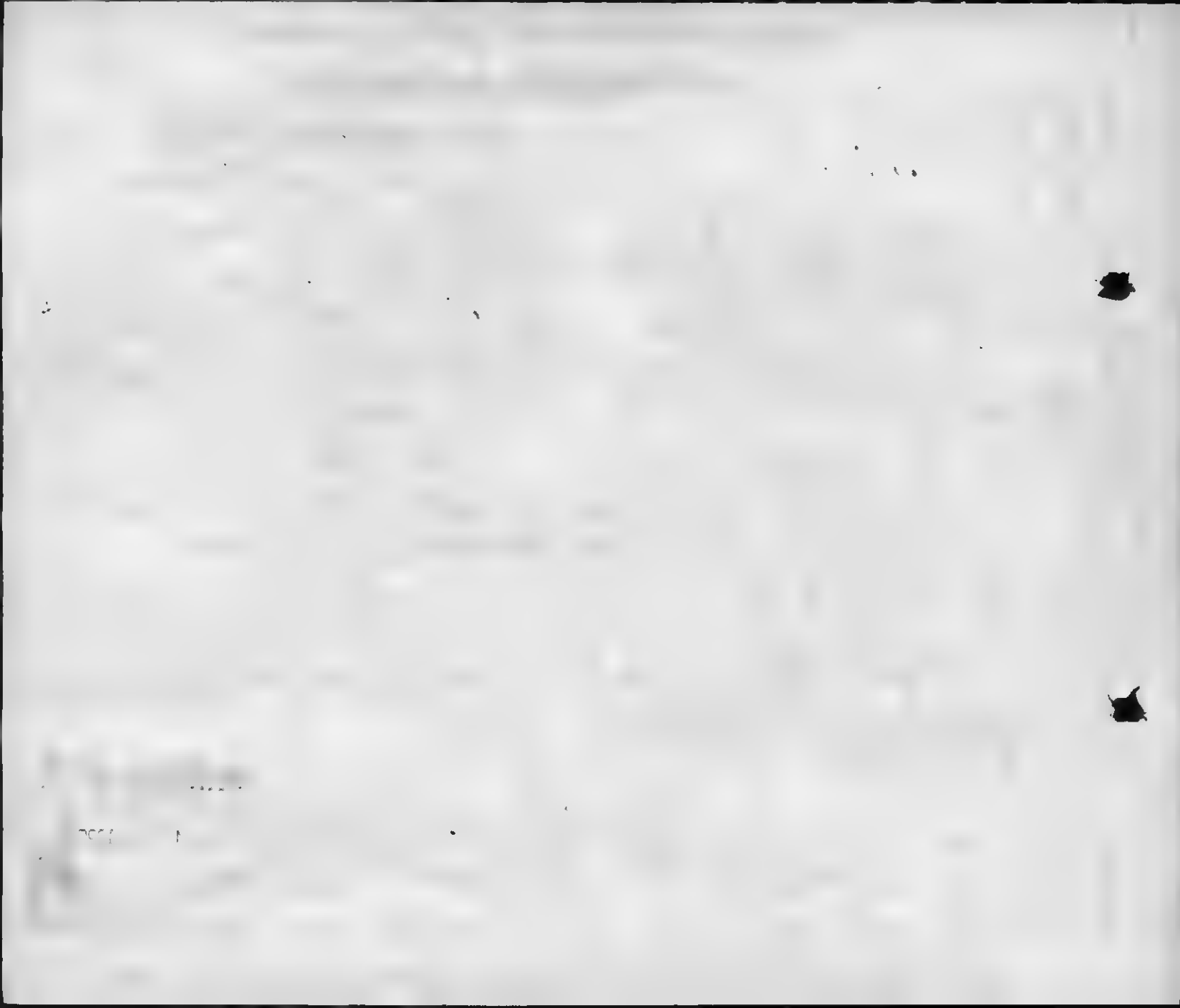
MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01142

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Morchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>11 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springhill Sanitarium</u>				STREET ADDRESS (If rural give location) <u>Front St</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>MARGARET</u> (Middle) <u>M.</u> (Last) <u>Cluff</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN 20 19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Wid.</u>	8. DATE OF BIRTH <u>June 28 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cwn Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Milbourne</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Dashfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Mrs Thos. H Smith, Shelton, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Basal cell Carcinoma left groin</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 17</u> , 19 <u>56</u> , to <u>JAN 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-19</u> , 19 <u>56</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Fuzula Tuley</u>		M.D.		ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's Episcopal</u>		LOCATION (City, town, or county) (State) <u>Pocomoke, Md</u>	
24. REC'D. BY REGISTRAR <u>Mary M. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u>		ADDRESS <u>Pocomoke, Md</u>	
DATE							



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02285
Reg. Dist.

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Michigan</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Detroit</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shoemaker Road</u>				STREET ADDRESS (If rural, give location) <u>6017-14th Street</u>			
3. NAME OF DECEASED: (Type or Print) <u>Michael Henry DeKeyser (AKA Hauck)</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>14</u> (Year) <u>19 56</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Aug. 31, 1938</u>	9. AGE last birthday: <u>17</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>U. S. N.</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>U. S. Navy</u>		11. BIRTHPLACE (State or foreign country): <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Michael H. DeKeyser</u>				14. MOTHER'S MAIDEN NAME: <u>Anna Busic</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY No.: <u>at death 380-34-8616</u>		17. INFORMANT & ADDRESS: <u>Mrs Catherine J Hauck 6017-14th St., Detroit, Mich.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Sudden			
Immediate cause (a) <u>Fractured cervical spine</u>							
DUE TO							
Antecedent cause(s) (b) <u> </u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u> </u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u> </u>				19b. MAJOR FINDING OF OPERATION: <u> </u>			
20. AUTOPSY? <u>X</u> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Roadside</u>		21c. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 14 56 2:30</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car he was driving ran into mill.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u> </u>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-14-56</u>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u> </u>		DATE THEREOF: <u>1-21-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Grand Lawn Cemetery</u>		LOCATION (City, town, or county): <u>Detroit, Michigan</u> (State) <u> </u>	
DATE REC'D BY LOCAL REG: <u>2-8-56</u>		REGISTRAR'S SIGNATURE: <u>Mary W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Thomas F. Waller</u>		ADDRESS: <u>Salisbury, Md.</u>	

3-11

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be attached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01143

4167
Item 3: film 0193 3-5-56L

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>37 Yrs.</u>		TOWN <u>Salisbury</u>		STREET ADDRESS (If rural give location) <u>102 West London Ave.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 West London Ave.</u>				STREET ADDRESS <u>102 West London Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>William Walter Sydney Dougherty</u>				4. DATE OF DEATH (Month) <u>1</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Oct. 12, 1883</u>	
9. AGE last birthday <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commerical</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Sydney C. Dougherty</u>		14. MOTHER'S MAIDEN NAME <u>Anna Gordon</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, po, or unk.) <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>214-10-9939</u>		17. INFORMANT & ADDRESS <u>William B. Dougherty, New Castle Del.</u>		18. MEDICAL CERTIFICATION		19. INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
IMMEDIATE CAUSE (A) <u>Acute Congestive Heart Failure</u>				ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>M.</u> <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/>	
21e. INJURY OCCURRED <u>White</u> <input type="checkbox"/> <u>Not white</u> <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from <u>Sept 1954</u> , to <u>1-23</u> , 1956, that I last saw the deceased alive on <u>1-24</u> , 1956, and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.		DATE SIGNED <u>1-24-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR <u>Jan. 26/1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hallaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Norman T. Baker</u>		ADDRESS <u>The Hill & Johnson Co. Salisbury, Md.</u>	

BUKHOV S. E.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1168

CERTIFICATE OF DEATH

01144

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Worcester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		<u>3 days</u>		TOWN <u>Ocean City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>CELIA ANNORA ELLIOTT</u>				4. DATE OF DEATH (Month) <u>January</u> (Day) <u>19</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 29, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Deal Island, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bradsher Messick</u>				14. MOTHER'S MAIDEN NAME <u>Annora Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Randolph Harrison--Ocean City, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u> </u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/18/56</u>, 19<u> </u>, to <u>1/19/56</u>, 19<u> </u>, that I last saw the deceased alive on <u>1/17/56</u>, 19<u> </u>, and that death occurred at <u> </u> M., from the causes and on the date stated above.							
SIGNATURE <u>Mary W. Holloman</u> M.D.		ADDRESS (Street, city, town, state) <u>226 E. Harrison St.</u>		DATE SIGNED <u>1/19/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 22, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Crisfield Cemetery</u>		LOCATION (City, town, or county) (State) <u>Crisfield, Md.</u>	
24. REC'D BY REGISTRAR <u>DATE 1-27-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons--Crisfield, Md.</u>			

U.S. AIR FORCE

AFV 30 1000

1000 30 AFV

1160

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS (If rural give location) <u>Sheldon Avenue</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Gladden</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 4 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Never</u>	8. DATE OF BIRTH <u>1-3-56</u>	9. AGE last birthday yrs. <u>1</u> mo. <u>18</u> days <u>54</u>		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward M. Gladden</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Gravenor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Edward M. Gladden Sheldon Ave Salisbury Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
11.2.0 IMMEDIATE CAUSE (A) <u>Cinnoxia</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Hyaline Membrane</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/3</u> , 19 <u>56</u> , to <u>1/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/4/56</u> , 19 <u>56</u> , and that death occurred at <u>8:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury</u>		DATE SIGNED <u>1/4/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/5/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR <u>Mary J. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas F. Wallace</u>		ADDRESS <u>Salisbury, Md.</u>	
DATE							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

J. V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12 '1

CERTIFICATE OF DEATH

01146

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> <u>md</u> MARYLAND CITY (If outside corporate limits, write RURAL OR TOWN) <u>Chillicothe</u> LENGTH OF STAY (in this place) <u>Life</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chillicothe</u> OR TOWN STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Joshua W. Gordy</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>8</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>2-5-11</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION, (Give kind of work done during most of working life, even if retired) <u>Reborn</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Parsonsburg</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Gordy</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Gordy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>17-09-2758</u>		17. INFORMANT'S ADDRESS <u>Gertrude Galt</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Arteriosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 yr.</u>	
19. DATE OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/6</u> 19 <u>56</u> to <u>1/8/56</u> 19 <u>56</u> , that I last saw the deceased <u>alive on 1/8/56</u> 19 <u>56</u> , and that death occurred at <u>7:30 PM</u> on the date stated above.							
SIGNATURE <u>Willie Seckler</u> M.D.				DATE SIGNED <u>1/8/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Glass Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parsonsburg md</u>	
24. REC'D BY REGISTRAR DATE <u>1-13-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. Laust</u>			



INSTRUCTIONS

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TO ATTENDING PHYSICIAN & HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1170

CERTIFICATE OF DEATH

01147

Item 4, Film 9192 1-31-56 et

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Traskin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Thomas Hackett</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>January 18, 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>3/15/1877</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Dun Farm</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Dun Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13. FATHER'S NAME <u>Harry Hackett</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Hortense Hall Traskin, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bangore Rt. foot</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Atherosclerosis, generalized</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-16</u>, 19<u>56</u>, to <u>1-18</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1-18</u>, 19<u>56</u>, and that death occurred at <u>12:10</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Mitchell W. Bush</u> M.D.				ADDRESS (Street, city, town, state) <u>Peninsula Gen. Hosp. Salisbury, Md.</u>		DATE SIGNED <u>1-19-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Traskin Cemetery</u>		LOCATION (City, town, or county) (State) <u>Traskin, Md.</u>	
24. REC'D BY REGISTRAR <u>1-25-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Messick</u>		ADDRESS <u>Bivolve, Maryland</u>	

RECEIVED

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U.S. DEPT. OF JUSTICE
RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

122

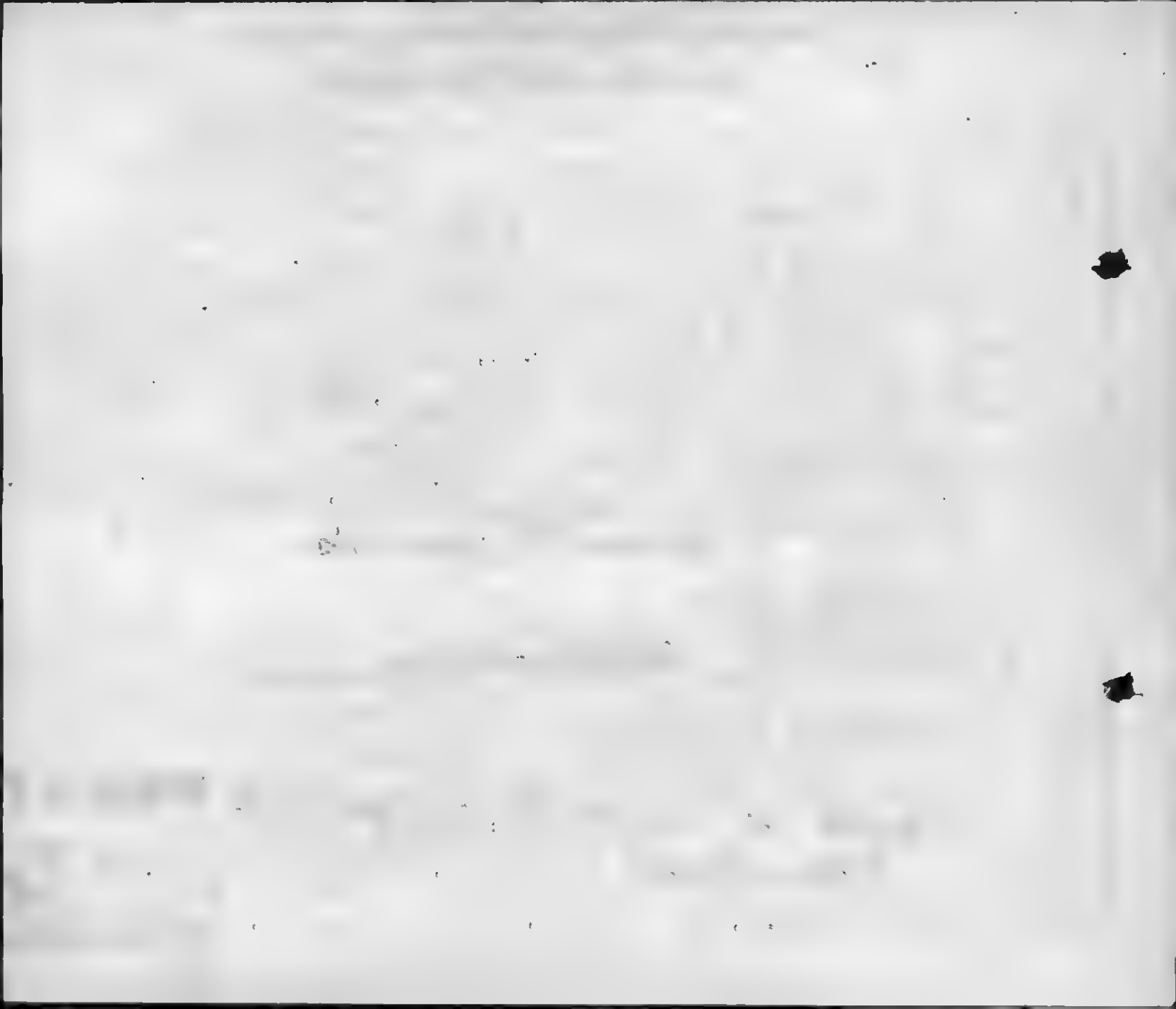
01148

CERTIFICATE OF DEATH

Dr. Emerick

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Hebron		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Hebron			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church St				STREET ADDRESS (If rural give location) Church St.			
3. NAME OF DECEASED (Type or Print) HETTIE (First) ELIZABETH (Middle) HARRISON (Last)				4. DATE OF DEATH (Month) Jan. (Day) 19th (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Dec. 19, 1866		9. AGE last birthday 89 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Work		10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Selbyville, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Hosier				14. MOTHER'S MAIDEN NAME Ann Mariah			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Vernon Killian (Daughter) Church St. Hebron, Maryland			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Chronic Myocardial Infarction							
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Arteriosclerosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 1st, 1956, to Jan 1st, 1956, that I last saw the deceased alive on Jan 1st, 1956, and that death occurred at 7:50 P.M. from the causes and on the date stated above.							
SIGNATURE William Emerick M.D. Hebron, Maryland				DATE SIGNED Jan. 20 1956			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Jan. 22, 1956		Hebron, Cemetery		Hebron, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 23 1956		Mary A. Holloway		HOLLOWAY & COMPANY		SALISBURY MARYLAND	



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1203

01149

CERTIFICATE OF DEATH

Dr. Burton

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 3 (Mt. Hermon Rd)				STREET ADDRESS (If rural give location) R.D. # 3 (Mt. Hermon Rd)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) THOMAS (Middle) ASBURY (Last) HEARN				(Month) Jan. (Day) 14th (Year) 1956			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH July 16, 1878	9. AGE last birthday 77 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months 5	Days 28	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY On own Farm		11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Alfred Hearn				14. MOTHER'S MAIDEN NAME Mariah Jane Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Ezra Frances Hearn (Wife) R.D. # 3 (Mt. Hermon Rd) Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X				IMMEDIATE CAUSE (A) Cerebral Vascular Accident			
ANTECEDENT CAUSE(S) DUE TO				(B) Generalized atherosclerosis			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) Hypertension			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				Arteriosclerosis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/4 , 19 54 , to 12/14 , 19 55 , that I last saw the deceased alive on 12/14 , 19 55 , and that death occurred at 8:00 P.M. , from the causes and on the date stated above.							
SIGNATURE [Signature]				ADDRESS (Street, city, town, state) M.D. Maryland Ave. Salisbury, Maryland			
				DATE SIGNED Jan/16 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 17, 1956		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE Mary H. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
DATE							

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The Baltimore copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01150

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>WICOMICO</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>WORCESTER</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>SALISBURY</u>		LENGTH OF STAY (In this place) <u>3 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>POCOMOKE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>709 Clarke ave</u>			
3. NAME OF (First) (Middle) (Last) (Type or Print) <u>ELIZABETH</u> <u>HENDERSON</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>JANUARY</u> <u>24</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>OCT. 12-1866</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM J. MILLS</u>				14. MOTHER'S MAIDEN NAME <u>MARY J. TULL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT'S ADDRESS <u>MISS ELIZABETH HENDERSON</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>POCOMOKE MD.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic arteriosclerosis.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. PLACE (Home, farm, lecture, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. A. P. M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 21</u> , 19 <u>56</u> to <u>Jan 24</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan 24</u> , 19 <u>56</u> , and that death occurred at <u>12:45</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>Henry V. H. Watson</u>				ADDRESS (Street, city, town, state) <u>2260 Worcester St. Pocomoke MD.</u>		DATE SIGNED <u>1/24/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 27 1956</u>		NAME OF CEMETERY OR CREMATORY <u>SALEM M. E. CEM</u>		LOCATION (City, town, or county) (State) <u>POCOMOKE MD.</u>	
24. REC'D BY REGISTRAR <u>Jan. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Mary E. Hall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HENRY V. H. WATSON</u>		ADDRESS <u>POCOMOKE MD.</u>	

BUREAU V. S.

JAN 27 1900

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. SARTORIUS: Med. Exam (Purnell CARL Hickman)										01151									
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist.									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										No. 332									
1. PLACE OF DEATH:					2. USUAL RESIDENCE (HOME) OF DECEASED:														
COUNTY		Wicomico			MARYLAND		STATE		Md		COUNTY		Wicomico						
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Salisbury			LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		Salisbury		OR TOWN		Salisbury						
HOSPITAL OR INSTITUTION OR STREET ADDRESS		St. Francis Hospital			STREET ADDRESS		501 Priscilla St.		(If rural, give location)										
3. NAME OF DECEASED:					4. DATE OF DEATH					5. AGE at birth:			6. IF UNDER 1 YEAR		7. IF UNDER 24 HRS.				
(Type or Print) Purnell Carl Hickman					(Month) (Day) (Year) Jan 20 1956					yrs. 36			Months 19		Days 28				
5. SEX		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:		9. AGE at birth:		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.							
M		W		Married		March 22 1919		36		yrs. 19		Months 19		Days 28					
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):					10b. KIND OF BUSINESS OR INDUSTRY:					11. BIRTHPLACE (State or foreign country):					12. CITIZEN OF WHAT COUNTRY?				
Insurance					Quaker City Ins Co					Washington D.C.					U.S.				
13. FATHER'S NAME:					14. MOTHER'S MAIDEN NAME:														
Raymond E. Hickman					Mary Meare														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk):					16. SOCIAL SECURITY No.:					17. INFORMANT, & ADDRESS:									
No					(?)					Catherine M. Hickman (wife)									
18. MEDICAL CERTIFICATION										501 Priscilla St. Salisbury, Md.		INTERVAL BETWEEN ONSET AND DEATH							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:																			
Immediate cause										Skull Fractures with Brain destruction		Days +							
Antecedent cause(s)										Manner of Injuries - Undetermined									
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last										(b) (c)									
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.										Alcoholic breath on entry to hospital									
19a. DATE OF OPERATION:					19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY?					Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.					21b. PLACE (Home, farm, factory, OF street, office bldg, etc.)					21c. HOW DID INJURY OCCUR?									
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY					21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>					Undetermined									
Jan 18 1956																			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .																			
SIGNATURE										Purnell		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED			
																1/21/56			
23. BURIAL, CREMATION, REMOVAL (Specify):										DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)		(State)			
Burial										JAN 23 1956		PARSONS Cemetery		Salisbury Maryland					
DATE REC'D BY LOCAL REG.										REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS					
1-23-56										Mary W. Holloway		Holloway & Company		Salisbury Md.					

BUREAU Y. S.

1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01152

Item 9, File 3791-1-10-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> OR TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Snow Hill</u> STREET ADDRESS (If rural give location) <u>205 Federal Street</u>	
3. NAME OF DECEASED: (Type or Print) <u>Charles E Hill</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>JANUARY 6 1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 1, 1896</u>
9. AGE last birthday <u>59</u> yrs. <u>9</u> Months <u>3</u> Days <u></u> Hours <u></u> Min.		10. BIRTHPLACE (State or foreign country): <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Game Warden</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>State Employee</u>	
11. FATHER'S NAME: <u>Edward A. Hill</u>		12. MOTHER'S MAIDEN NAME: <u>Annie M. Bowen</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. SOCIAL SECURITY NO.	
15. INFORMANT & ADDRESS: <u>Mrs. Mattie E. Hill, Snow Hill, Md.</u>			
16. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>4500</u> IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u> ANTECEDENT CAUSE (B) <u>Cerebral Atherosclerosis</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic Heart Disease</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>2 days</u> <u>3 weeks</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>12/14/1955</u> to <u>1/1/1956</u> , that I last saw the deceased alive on <u>1/1/1956</u> , and that death occurred at <u>3:40 AM</u> , from the causes and on the date stated above. SIGNATURE <u>David J. Gilmore</u> M.D. <u>Salisbury, Md.</u> DATE SIGNED <u>Jan. 6 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-8-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Whatear Methodist</u>		LOCATION (City, town, or county) (State) <u>Snow Hill, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-7-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>	
24. FUNERAL DIRECTOR <u>Clay E. Dennis</u>		ADDRESS <u>Snow Hill, Md.</u>	

ROBERT V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

124

01153
Reg. Dist. No. 332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH: COUNTY <u>Wicomico</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R. F. D. #13, P. R. R. tracks.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Wicomico</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Fruitland</u> TOWN STREET ADDRESS (If rural, give location) <u>Rural</u>																									
3. NAME OF DECEASED: (Type or Print) <u>Anna</u> (First) <u>M</u> (Middle) <u>Hitchens</u> (Last)		4. DATE OF DEATH <u>1</u> <u>2</u> <u>19</u> <u>56</u> Month Day Year		5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 6, 1903</u>		9. AGE last birthday: <u>52</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Nursing Home.</u>		11. BIRTHPLACE (State or foreign country): <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>									
13. FATHER'S NAME: <u>James A. Hastings</u>						14. MOTHER'S MAIDEN NAME: <u>Rosa B. Adams</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)						16. SOCIAL SECURITY No.:						17. INFORMANT & ADDRESS: <u>Mrs. Vorch Eye, R F D # 3 Laurel, Del.</u>					
18. MEDICAL CERTIFICATION																													
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Fractured skull; crushed right chest.</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)																		INTERVAL BETWEEN ONSET AND DEATH: <u>Sudden.</u>											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.																													
19a. DATE OF OPERATION: <u>0</u>						19b. MAJOR FINDING OF OPERATION:						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. PLACE (Home, farm, factory, OF street, office bldg, etc., INJURY <u>R.R. tracks.</u>						21c. (City or town (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>																	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1</u> <u>2</u> <u>56</u> <u>7</u> AM.						21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>						21f. HOW DID INJURY OCCUR? <u>Collision of car and R.R. train.</u>																	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>Emile Rye</u> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>1-3-56</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>																													
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>						DATE THEREOF: <u>1/4/1956</u>						NAME OF CEMETERY OR CREMATORY: <u>PORTSVILLE CEMETERY</u>						LOCATION (City, town, or county) (State): <u>PORTSVILLE, DELAWARE</u>											
DATE REC'D BY LOCAL REG. <u>1-3-56</u>						REGISTRAR'S SIGNATURE: <u>Mary W. Holloman</u>						24. FUNERAL DIRECTOR: <u>Thomas F. Wallace</u>						ADDRESS: <u>Salisbury, Md.</u>											

BUREAU V. B.

JAN 5 1936

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>		CITY <u>Baltimore, Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Salisbury, Maryland</u>		<u>4 yr. 4 mo.</u>		STREET ADDRESS		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dea's Hospital</u>				<u>222 N. Strick St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Emma A Holland</u>				<u>Jan. 27 1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>May 2nd, 1877</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk</u>		9. AGE last birthday <u>78</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Unk</u>				14. MOTHER'S MAIDEN NAME <u>Delia Bonds</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>5 days</u>	
IMMEDIATE CAUSE (A) <u>Congestive Failure</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic heart</u>						<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>disease.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-11-51</u> to <u>1-27-56</u> , that I last saw the deceased alive on <u>1-27-56</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Reese Wm</u>		M.D. <u>Reese Wm</u>		ADDRESS (Street, city, town, state) <u>Baltimore</u>		DATE SIGNED <u>1-28-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-1-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Auburn Cmi</u>		LOCATION (City, town, or county) <u>Baltimore</u>	
24. REC'D BY REGISTRAR <u>1050</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Hopewell</u>		ADDRESS <u>512 Carverton Ave</u>	

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

EDMUND K. S.

FEB

KEGEL

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Lysabrin</u>		<u>Liptime</u>		TOWN <u>Lysabrin</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Reese</u> (Middle) <u>L.</u> (Last) <u>Hornor</u>				(Month) <u>1</u> (Day) <u>25</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7-10-1889</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months <u>8</u> Days <u>15</u>		Hours <u></u> M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Own Farm</u>		<u>Lysabrin, Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>James Hornor</u>				14. MOTHER'S MAIDEN NAME <u>Luiccia Horley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mary Hornor, Lysabrin, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>				<u>5 years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10:45 A.M., 1949</u> to <u>25 Jan., 1956</u> , that I last saw the deceased alive on <u>25 Jan., 1956</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Richard H. Saunders, M.D.</u>				ADDRESS (Street, city, town, state) <u>Nantuxet, Md.</u>			
DATE THEREOF <u>1-28-56</u>				DATE SIGNED <u>1/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Mem. Park Cem.</u>		LOCATION (City, town, or county) <u>Salisbury, Md.</u>		(State) <u></u>	
24. REC'D BY REGISTRAR <u>956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>K. G. Messick, Brooke, Md.</u>		ADDRESS <u></u>	
DATE <u>1-28-56</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 JOM



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1175
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 01156

No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Virginia</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Arlington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tony Tank Bridge</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Henry</u>		(Middle) <u>Bell</u>		(Last) <u>Irvin</u>	
SEX: <u>M</u>		5. COLOR OR RACE: <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>28</u> (Year) <u>19 56</u>	
8. DATE OF BIRTH: <u>3-15-1913</u>		9. AGE last birthday: <u>42</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Fort Valley, Georgia</u>		11. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Unk.</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Unk.</u>			
13. FATHER'S NAME: <u>Salam Irving</u>				14. MOTHER'S MAIDEN NAME: <u>Angeline Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		(If Yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY No.: <u>unk.</u>		17. INFORMANT & ADDRESS: <u>M. S. Allen Fun. Home, Miami, Florida</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Fractured cervical spine</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Bridge</u>		21c. (City or town, County, State) <u>Salisbury</u> <u>Wicomico</u> <u>Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1 28 56 12:45 AM</u>		21e. INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car smashed into guard rail in car race.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>1-30-56</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>1-31-56</u>		NAME OF CEMETERY OR CREMATORY <u>Princeton Cemetery</u>		LOCATION (City, town, or county) (State) <u>Princeton, Fla.</u>	
DATE REC'D BY LOCAL REG. <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Mary A. Stewart</u> <u>Stewart Funeral Home, Salisbury, Maryland</u>			

W. H. R. 1000
CLARE

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1176

CERTIFICATE OF DEATH

01157

Dr. Beardsley

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Salisbury				TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 304 South Haven Ave				STREET ADDRESS (If rural give location) 304 South Haven Ave.			
3. NAME OF DECEASED (First) (Middle) (Last) FRANK ARTHUR JENKINS				4. DATE OF DEATH (Month) (Day) (Year) Jan. 24 th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH October 7, 1903		9. AGE last birthday 52 yrs.	IF UNDER 1 YEAR Months 3 Days 17	IF UNDER 24 HRS. Hours 17 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painter		11. BIRTHPLACE (State or foreign country) St. Mary's County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis Jenkins				14. MOTHER'S MAIDEN NAME Martha Malone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Mary Jenkins (Wife) 304 South Haven Ave Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4 - 0 - 1 IMMEDIATE CAUSE (A) Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
ANTECEDENT CAUSE(S) DUE TO Coronary atherosclerosis				1 yr.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-14, 1956, to 1-24, 1956, that I last saw the deceased alive on 1-24, 1956, and that death occurred at 6:00A.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. Beardsley</i>				ADDRESS (Street, city, town, state) East Church St Salisbury, Maryland			
DATE SIGNED Jan. 25/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 27, 1956		NAME OF CEMETERY OR CREMATORY Parsons Cemetery		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			
DATE JAN 30 1956							

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1177
CERTIFICATE OF DEATH

Dr. Morgan

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>		12	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Parsons Memorial Hospital</u>				STREET ADDRESS (If rural give location) <u>212 Hazel Ave.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Jesse B. Johnson Jr.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 15 19 56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Jan. 6, 1956</u>	9. AGE last birthday <u>0</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Pen. Gen. Hosp. Salisbury Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jesse Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>RECEIVED</u>		17. INFORMANT & ADDRESS <u>Mr. Jessie Johnson (Father) 212 Hazel Ave. Salisbury, Maryland</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
774X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>						<u>1 hr</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Prematurity</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Fatty Degeneration of Liver</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Intrauterine Anoxia</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/16</u> , 19 <u>56</u> , to <u>1/15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>56</u> , and that death occurred at <u>2:55</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Morgan</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>1/15/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>			

INSTRUCTIONS:

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VE 15C 1-55 10M

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

BUREAU V. B.

JAN 17 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 4MC 1-58 10M

1178

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

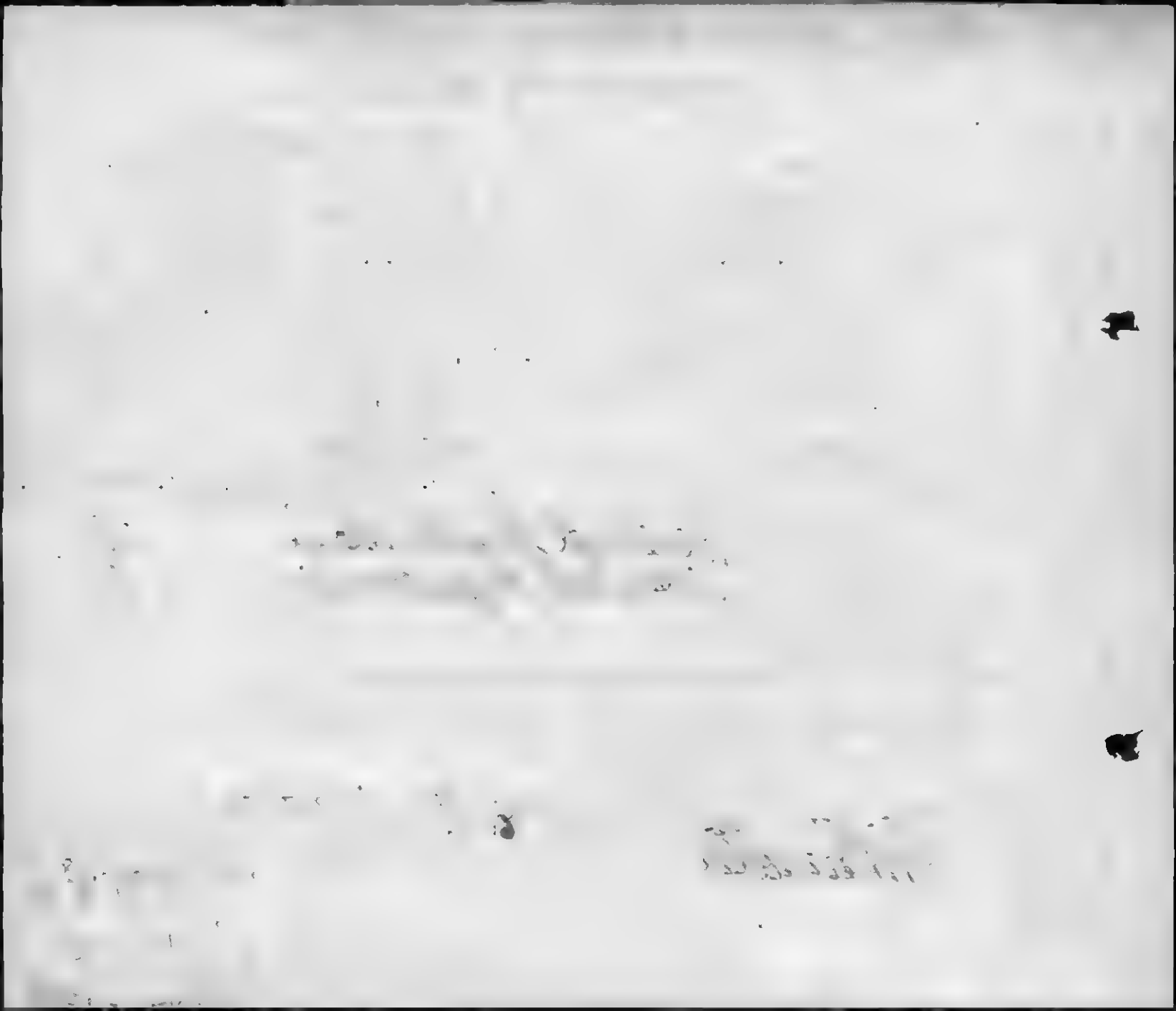
01158

CERTIFICATE OF DEATH

Dr. Beardsley

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D.# 4 (Johnson Road)			
3. NAME OF DECEASED (First) (Middle) (Last) ELWOOD MEDFORD JONES				4. DATE OF DEATH (Month) (Day) (Year) Jan. 27th 19 56			
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 7th, 1894		9. AGE last birthday 61 yrs.	IF UNDER 1 YEAR Months 4 Days 20	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Employee of Steele Junk Yard)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Harrington, Delaware		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Jones				14. MOTHER'S MAIDEN NAME Natilda Hammond			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Unk			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Elsie Steele (Sister) E. Vine St Ext. Salisbury, Maryland		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)				<i>Cerebral hemorrhage essential hypertension</i>		<i>1 day 1 yr.</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-27, 1956, to 1-27, 1956, that I last saw the deceased alive on 1-27, 1956, and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE <i>Dr. Beardsley</i>				DATE SIGNED M.D. East Church St Salisbury, Maryland Jan. 28/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan. 30/56		NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. REC'D BY REGISTRAR DATE Jan 30 1956		REGISTRAR'S SIGNATURE <i>Mary H. Holloway</i>		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND			



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1179 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01160

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Delaware</u> COUNTY <u>Sussex</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Selbyville</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>William J. Kitchens</u>				<u>January 7, 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>May 10, 1878</u>	
				9. AGE last birthday: <u>77</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, or as it retired): <u>Field Foreman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Nursery</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Theodore Kitchens</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Baker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>—</u>				16. SOCIAL SECURITY NO.: <u>222-20-3228</u>		17. INFORMANT & ADDRESS: <u>Anna Kitchens, Selbyville, Del.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Insufficiency</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Heart Disease</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Pulmonary Emphysema</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/31</u> , 19 <u>56</u> , to <u>1/7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/7</u> , 19 <u>56</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David J. Bilmore</u>		M. D. <u>Salisbury Md.</u>		DATE SIGNED <u>Jan. 7, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Selbyville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-9-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		24. FUNERAL DIRECTOR <u>Peter Whaley</u>		ADDRESS <u>Selbyville, Del.</u>	

BUREAU V. S.

JAN 11 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1276

01161

Reg. Dist. No. 332

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>15 yrs</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Salisbury md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>Rural</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Clifford</u>		(Middle)		(Last) <u>Lewis</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>1928</u>	
				9. AGE last birthday: <u>38</u> yrs.		4. DATE OF DEATH: (Month) <u>1</u> (Day) <u>24</u> (Year) <u>1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY No.: <u>224-14-8174</u>		17. INFORMANT & ADDRESS: <u>Letter L Williams</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Broncho-pneumonia.</u>						Sudden.....	
DUE TO							
Antecedent cause(s) (b).....							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
DUE TO							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Emile Rye</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-24-56</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1-29-56</u>		NAME OF CEMETERY OR CREMATORY: <u>Green Acres Cem</u>		LOCATION (City, town, or county) (State) <u>md</u>	
DATE REC'D BY LOCAL REG. <u>1-29-56</u>		REGISTRAR'S SIGNATURE: <u>Marj W. Holloway</u>		24. FUNERAL DIRECTOR: <u>Booker M. West</u>		ADDRESS	

BUREAU V. S.

FEB 1 1956

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1180

CERTIFICATE OF DEATH

Reg. Dist. No.

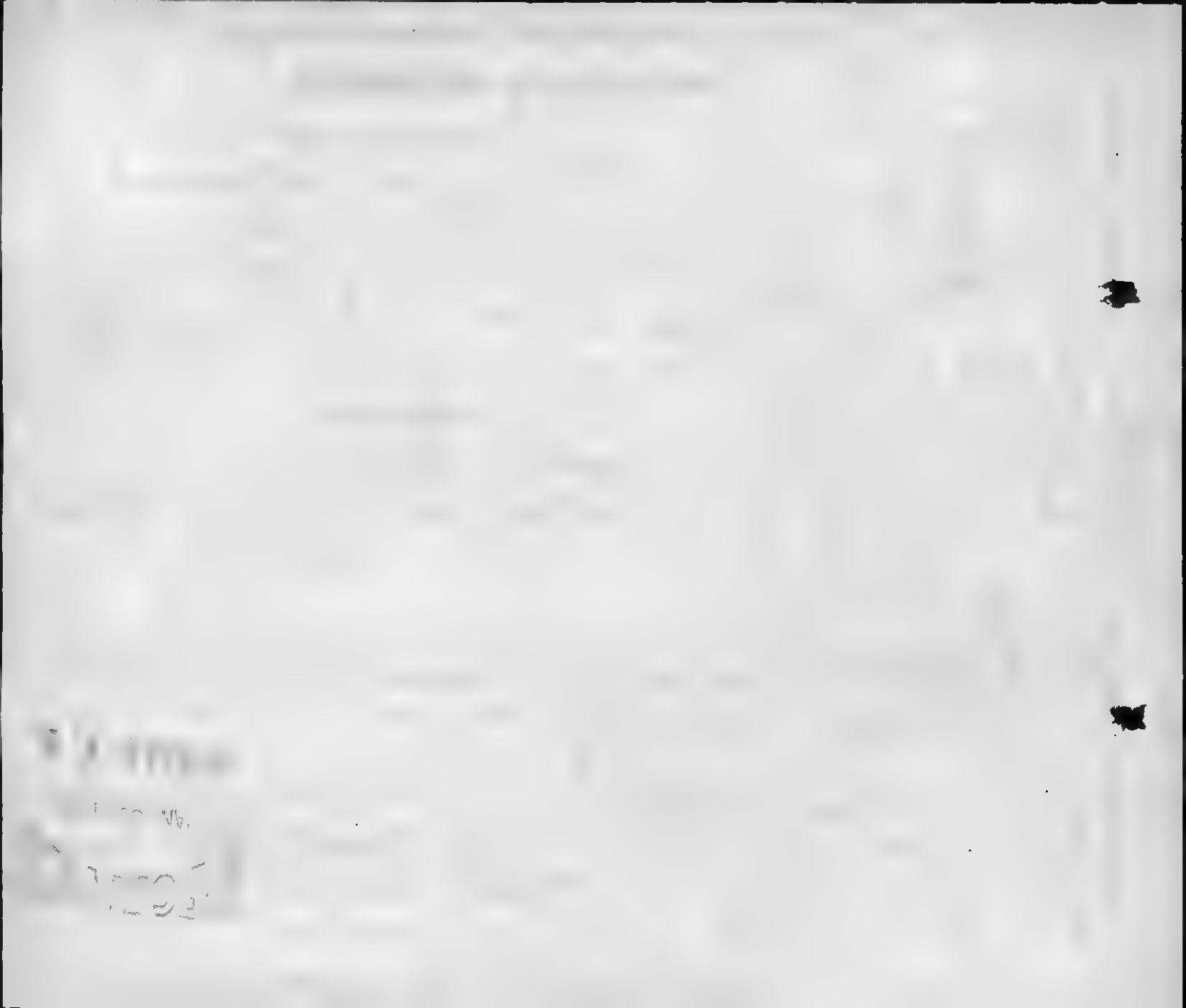
1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Md.</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>3 days</u>		TOWN <u>Salisbury</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Perinatal Gen. Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) <u>SHARAH E. MACK</u>				4. DATE OF DEATH <u>January 22-1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>E</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12-1900</u>	
9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR <u>9</u> Months <u>18</u> Days		10. IF UNDER 24 HRS. <u>5</u> Hours <u>18</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Nantux, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Asbury Barclay</u>			
14. MOTHER'S MAIDEN NAME <u>Belotto</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>229-267607</u>				17. INFORMANT & ADDRESS <u>Joseph Mack, Nantux, Md.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerosis</u>							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. DATE OF OPERATION				21b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 13, 1956</u> , to <u>Jan 22, 1956</u> , that I last saw the deceased alive on <u>Jan 22, 1956</u> , and that death occurred at <u>2:26 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Quirina J. Lewis</u>				DATE SIGNED <u>Jan 22, 1956</u>			
ADDRESS (Street, city, town, state) <u>226 N. Main St., Salisbury, Md.</u>				DATE SIGNED <u>Jan 22, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. DATE THEREOF <u>1/26/56</u>			
NAME OF CEMETERY OR CREMATORY <u>Nantux Cem.</u>				LOCATION (City, town, or county) (State) <u>Nantux, Md.</u>			
25. REC'D BY REGISTRAR <u>May H. Holloway</u>				26. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Messitt</u>			
DATE <u>Jan 26, 1956</u>				ADDRESS <u>Nantux, Md.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



01163

CERTIFICATE OF DEATH

Reg. Dist. No.

1181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>		LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>82 PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>PACIFIC AVE</u>		<u>1</u>	
3. NAME OF DECEASED (Type or Print) <u>Virginia BOUNDS</u> (First) <u>MALONE</u> (Middle) (Last)				4. DATE OF DEATH <u>JANUARY 13</u> 19 <u>56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 17 1913</u>	9. AGE last birthday <u>42</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK BOUNDS</u>				14. MOTHER'S MAIDEN NAME <u>MERTLE LECATES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-20-4210</u>		17. INFORMANT & ADDRESS <u>RUSSELL MALONE SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
441X IMMEDIATE CAUSE (A) <u>Chronic Poisoning</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive C.V. Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Malignant Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-12</u> , 19 <u>56</u> , to <u>1-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-13</u> , 19 <u>56</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Mary B. Smith</u> M.D.				DATE SIGNED <u>Salisbury Ind. 1-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>1/16/1956</u>		NAME OF CEMETERY OR CREMATORY <u>ALLEN CEMETERY</u>		LOCATION (City, town, or county) (State) <u>ALLEN, MARYLAND</u>	
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE <u>Mary B. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Hill Johnson Co. Salisbury, Md.</u>		ADDRESS <u>Norman F. Baker</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

BUREAU V. S.

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01164

182

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>St. Mary's</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 11/28/55</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Piney Point</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>William</u> <u>Abell</u> <u>Medley</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan</u> <u>18</u> <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 5, 1902</u>	9. AGE last birthday <u>53</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Medley's Neck, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Medley</u>				14. MOTHER'S MAIDEN NAME <u>Ida Redburn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-18-2743</u>		17. INFORMANT & ADDRESS <u>self when admitted to hospital</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/28</u> , 19 <u>55</u> , to <u>1/18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/18</u> , 19 <u>56</u> , and that death occurred at <u>5:40</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>St. Mary's Hosp. Pine Bluff Hosp. Salisbury</u>				ADDRESS (Street, city, town, state)		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan 23, 1956</u>		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Dunnington</u>		ADDRESS <u>2 Woodruff</u>	

N^o

1. INSTRUCTIONS TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital attending physician.

2. INSTRUCTIONS TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01165

Reg. Dist. No. 337

Dr. Insley

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Wicomico	MARYLAND	STATE Maryland	COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 4 (Ocean City Rd)		STREET ADDRESS (If rural give location) R.D. # 4 (Ocean City Rd)	
3. NAME OF DECEASED (Type or Print) (First) ALVERNON (Middle) (Last) MESSICK		4. DATE OF DEATH (Month) (Day) (Year) Jan. 29th 19 56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Sept. 30, 1864
9. AGE last birthday 91 yrs.		10. IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpenter	
11. BIRTHPLACE (State or foreign country) Sussex County, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Clayton H. Messick		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Tyndall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mrs. Willie May Messick (Wife) R.D. # 4 (Ocean City Rd) Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Cardio-vascular Renal Disease		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1957 , to 1-29 , 19 56 , that I last saw the deceased alive on 1-25 , 19 56 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
SIGNATURE Thos. A. Insley		ADDRESS (Street, city, town, state) M.D. East Main St. Salisbury, Maryland	
DATE SIGNED Jan. 30/56			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF Feb. 1, 1956	
NAME OF CEMETERY OR CREMATORY Ansbury Church Cemetery		LOCATION (City, town, or county) (State) Laurel-Georgetown Rd. Del.	
24. REC'D BY REGISTRAR Feb. 2, 1956		REGISTRAR'S SIGNATURE Mary H. Holloway	
25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

RECEIVED

FEB 2

1950

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this the bottom copy may be retained by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

1183

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01166

CERTIFICATE OF DEATH

Dr. Fisher

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pen. Gen. Hospital</u>				STREET ADDRESS (If rural give location) <u>127 East Philadelphia Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>ELIZABETH</u> (Last) <u>NIBLETT</u>				(Month) <u>JAN.</u> (Day) <u>1 st</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Mar. 15, 1907</u>		9. AGE last birthday <u>48</u> yrs	10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Employee (Ironer) at Sunshine Laundry</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wicomico Co. Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Orlanda Lemon</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Sturgis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. June Lambert (Daughter) R.D. # 2 Hamilton, New York</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Metastatic carcinoma of both lungs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma of st. breast</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-16, 1954</u> , to <u>1-1, 1956</u> , that I last saw the deceased alive on <u>1-1, 1956</u> , and that death occurred at <u>1:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William H. Stump</u>				ADDRESS (Street, city, town, state) <u>M.D. Medical Center Salisbury, Maryland Jan. 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 5, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	

BUREAU V. S.

JAN 5 1956

RECEIVED

01167

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>MARYLAND</u>		STATE <u>Delaware</u>		COUNTY <u>Sussex</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>				TOWN <u>Rural - Bethel</u>		<u>4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Seaford General Hospital</u>				STREET ADDRESS (If rural give location) <u>Bethel - Seaford Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Victor</u>				4. DATE (Month) (Day) (Year) <u>DEATH January 19, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>June 29, 1900</u>	
9. AGE last birthday <u>55</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William O'Day</u>				14. MOTHER'S MAIDEN NAME <u>Victoria Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>2-2-09-6672</u>		17. INFORMANT & ADDRESS <u>Gertrude O'Day, 180 Bethel, Delaware</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Artery Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., M. from the causes and on the date stated above.							
SIGNATURE <u>David J. Selman M.D.</u>				ADDRESS (Street, city, town, state) <u>Salisbury Md</u>		DATE SIGNED <u>Jan 19, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Willisburg, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Williamson Salisbury Md.</u>		ADDRESS	
DATE <u>Jan. 24 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-58

BUREAU V. S.

JAN 10 1900

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury</u>		1 year		TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location) <u>1. T. 11. Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. AGE last birthday	
(First) <u>William</u> (Middle) <u>John</u> (Last) <u>Parker</u>				(Month) <u>Jan.</u> (Day) <u>30</u> (Year) <u>1956</u>		69 yrs.	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/13/1896</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Watchman</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John William Parker</u>				14. MOTHER'S MAIDEN NAME <u>Margaret E. Sturgis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>W.W.#1</u>				16. SOCIAL SECURITY NO. <u>213-14-1665</u>		17. INFORMANT & ADDRESS <u>Mrs. Lee F. Truitt-(Sister) R.D.# 5 Maple Way-Salisbury Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Acute myocardial insufficiency</u>				24 hrs			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic cardiovascular disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronch. pneumonia</u>				3 mos			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 6</u> , 19 <u>55</u> , to <u>Jan. 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 30</u> , 19 <u>56</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>V. Juerman</u>				ADDRESS (Street, city, town, state) <u>V. Juerman, M.D. 1113 Salisbury Rd. Salisbury Md.</u>		DATE SIGNED <u>1/31/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 2, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Deer's Head Cemetery</u>		LOCATION (City, town, or county) <u>Salisbury Md.</u>	
24. REG. BY REGISTRAR <u>Mary H. Holloway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Holloway & Co</u>		ADDRESS <u>Salisbury Md.</u>	
DATE <u>Feb. 1, 1956</u>							

INSTRUCTIONS: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55

BUREAU V. S.

FEB 1 1950

RECEIVED

186

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>				STREET ADDRESS <u>Box 12</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Phibben</u>				<u>January 2, 1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>January 2, 1906</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Rebald Kenneth Phibben</u>				14. MOTHER'S MAIDEN NAME <u>Shirley Fay Hughes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Pulmonary atelectasis</u> ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pneumonia</u> II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/2/56</u>, 19<u>56</u>, to <u>1/2/56</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/2/56</u>, 19<u>56</u>, and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. ADDRESS (Street, city, town, state) <u>Delmar Md.</u> DATE SIGNED <u>1-4-56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>1-5-56</u>		NAME OF CEMETERY OR CREMATORY <u>Peninsula General Hospital Salisbury, Wicomico Md.</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR DATE <u>1-5-56</u>		REGISTRAR'S SIGNATURE <u>Mary W. Holloman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Peninsula General Hospital</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN & HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1187 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01170

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Virginia</i>		COUNTY <i>Accomack</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <i>Salisbury</i>				TOWN <i>Chancock</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Penninsula General Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH			
John Polliard				January 3- 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
male	white		Aug 24, 1891	64 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Plumber				dancer		Pennsylvania	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Albert W. Polliard				Elsie Patterson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						Mrs. J. L. Polliard, Chancock, Va.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)							
Anterior pneumonia							
ANTECEDENT CAUSE (B)							
Carcinoma of bladder							4 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?
1-1-56			Bladder overgrown carcinoma				YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from 12-30, 1955, to 1-3, 1956, that I last saw the deceased alive on 1-3, 1956, and that death occurred at 4 PM, from the causes and on the date stated above.							
SIGNATURE <i>William H. Fisher</i>				ADDRESS <i>Chancock, Va.</i>		DATE SIGNED <i>1-3-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-5-56		Chancock		Chancock, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR:		ADDRESS	
1-4-56		Mary W. Holloway		Patrick Thilligman			

W. A. WATSON

W. A. WATSON

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1188

CERTIFICATE OF DEATH

02311

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Md</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (In this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Upper Hill</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula General Hospital</u>		STREET ADDRESS (If rural, give location) <u>and</u>					
3. NAME OF DECEASED (Type or Print) <u>Jessie Pruitt</u>				4. DATE OF DEATH (Month) <u>JAN</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>none</u>	8. DATE OF BIRTH <u>1-3-1896</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Cemden N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Howard Pruitt</u>				14. MOTHER'S MAIDEN NAME <u>Anna E. Hayes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>103-61-6582</u>		17. INFORMANT & ADDRESS <u>Willie M. Pruitt</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarct, acute</u>				<u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
19. DATE OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-27</u> , 19 <u>56</u> , to <u>1-29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-29</u> , 19 <u>56</u> , and that death occurred at <u>10:45</u> M. from the causes and on the date stated above.							
SIGNATURE <u>William R. Edles, Jr.</u>				DATE SIGNED <u>1-29-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>mt. Peace Cem</u>		LOCATION (City, town, or county) (State) <u>Cemden N.J.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary W. Hollman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Benker M. Black</u>		ADDRESS <u>Salisbury Md.</u>	
DATE <u>2-8-56</u>							

2/11/19

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INSTRUCTIONS

TO ATTENDING PHYSICIAN AND HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A-15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01171

1189

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		CITY OR TOWN <u>SALISBURY</u>		STATE <u>MARYLAND</u> COUNTY <u>Worcester</u>		CITY OR TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>		LENGTH OF STAY (in this place)		STREET ADDRESS <u>304 MARKET</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>MATILDA D. RANDALL</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 13 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Dec. 16, 1867</u>	9. AGE last birthday <u>88</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Theodore Derr</u>				14. MOTHER'S MAIDEN NAME <u>Annie M. Crouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) <u>--</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Pocomoke City, Md.</u> <u>Rev. Louis C. Randall-304 Market St.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-8</u>, <u>1956</u>, to <u>1-13</u>, <u>1956</u>, that I last saw the deceased alive on <u>1-13</u>, <u>1956</u>, and that death occurred at <u>11:25</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William R. Elder, Jr.</u> M.D.				DATE SIGNED <u>Salisbury, Md. 1-13-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Westminster Cem.</u>		LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
24. REC'D BY REGISTRAR <u>January 14 1956</u>		REGISTRAR'S SIGNATURE <u>Ruby Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. F. Travers & Sons - Baltimore</u>		ADDRESS <u>Md.</u>	

BUREAU V. S.

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01172

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CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Salisbury, Maryland</u>		<u>10 days</u>		TOWN <u>Rhodesdale, Md.</u>		<u>04A</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Elmer</u> (First) <u>Douglas</u> (Middle) <u>Spear</u> (Last)				4. DATE OF DEATH <u>1</u> - <u>15</u> - <u>1956</u> (Month) (Day) (Year)			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 23, 1927</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer on Ferry Boat</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>W. J. Spear</u>				14. MOTHER'S MAIDEN NAME <u>Sara Alice Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unk.) <u>unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
1. IMMEDIATE CAUSE (A) <u>Generalized Carcinomatosis</u>						<u>?</u>	
2. ANTECEDENT CAUSE(S) DUE TO (B) <u>Ca. of colon</u>						<u>9 yrs.</u>	
3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 5, 1956</u> to <u>Jan. 15, 1956</u> , that I last saw the deceased alive on <u>Jan. 15, 1956</u> , and that death occurred at <u>4:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>V. Walder</u>				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>1/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/17/56</u>		NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		LOCATION (City, town or county) (State) <u>East New Market, Md.</u>	
24. REG'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mary H. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Keith S. Willoughby</u>		ADDRESS	
DATE <u>Jan. 19, 1956</u>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1191 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18
Item 18 Film G191 1-19-56

01173

CERTIFICATE OF DEATH

Dr. Mitchell-Burton

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		STATE MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Salisbury		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital				STREET ADDRESS (If rural give location) R.D. # 1 (Shad Point)			
3. NAME OF DECEASED (First) EVA (Middle) MAE (Last) SPENCER				4. DATE OF DEATH (Month) JAN. (Day) 7 th (Year) 19 56			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Sept. 10, 1881	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Own Home		11. BIRTHPLACE (State or foreign country) Shad Point, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Henry T. Todd				14. MOTHER'S MAIDEN NAME Mary Ann Fletcher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. James H. Spencer (Son) R.D. # 2 Salisbury, Maryland			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) CVA, -- Cerebro Vascular Accident				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-10, 1956, to 1-7, 1956, that I last saw the deceased alive on 1-7, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
SIGNATURE A. C. Mitchell M.D.				DATE SIGNED ADDRESS (Street, city, town, state) Maryland Ave. Salisbury, Maryland Jan. 9 / 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Jan 10-1956		NAME OF CEMETERY OR CREMATORY Shad Point Cemetery		LOCATION (City, town, or county) (State) Shad Point (R.D. # Salisbury) Md	
24. REC'D BY REGISTRAR DATE 1 1956		REGISTRAR'S SIGNATURE Mary T. Holloway		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	

CHAS. H. BENTON

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W. C. BENTON

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Wicomico</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL or give nearest town) TOWN <i>Salisbury</i>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Princess Anne</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Paul</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>January 5 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Jan. 17, 1895</i>	
				9. AGE last birthday <i>60</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Produce broker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Produce</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
13. FATHER'S NAME <i>George Sterling</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Gladden</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>216-114-2161</i>		17. INFORMANT & ADDRESS <i>Henry Sterling, Salisbury, Md.</i>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<i>6 days</i>			
IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage</i>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Central Nervous System Syphilis Unknown</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (Country) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec 29, 1955</i> to <i>Jan 5, 1956</i> that I last saw the deceased alive on <i>Jan 4, 1956</i> and that death occurred at <i>6:10 PM</i> from the causes and on the date stated above.							
SIGNATURE <i>David L. Schumacher</i>		DATE THEREOF <i>Jan. 7, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>St. Andrews Cemetery</i>		LOCATION (City, town, or county) (State) <i>Princess Anne, Md.</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		24. REC'D BY REGISTRAR <i>Mary W. Holloman</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Levin R. Wilson</i>		DATE SIGNED <i>Jan 5, 1956</i>	
DATE <i>1-5-56</i>		REGISTRAR'S SIGNATURE		ADDRESS			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10

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INSTRUCTIONS

TO ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

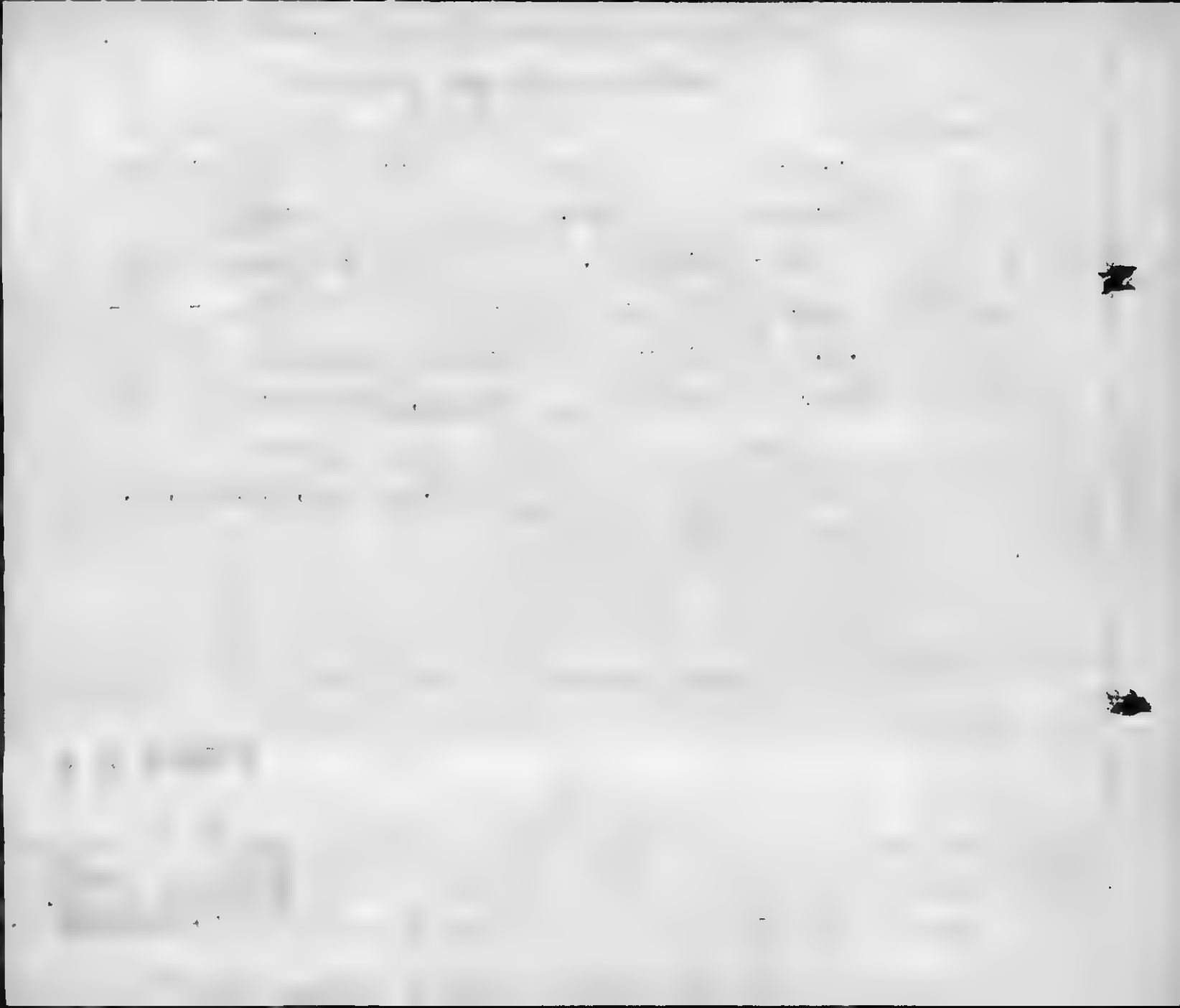
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01175

CERTIFICATE OF DEATH

Reg. Dist. No. . . .

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Fruitland</u>		LENGTH OF STAY (in this place) <u>6 mos.</u>		CITY OR TOWN <u>Fruitland</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>At home - Washington St.</u>				STREET ADDRESS <u>Washington Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>George Washington Stevens</u>				4. DATE (Month) (Day) (Year) <u>DEATH 1 - 12 - 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>A. A.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>About 1895</u>	9. AGE last birthday <u>About 61 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Raleigh, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Ora Grant, Fruitland, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4443X IMMEDIATE CAUSE (A) <u>Apoplexy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
ANTECEDENT CAUSE(S) (B) <u>Hypertensive Cardiovascular</u>				<u>undetermined</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) <u>Arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10 Oct.</u> 19 <u>55</u> to <u>12 Jan.</u> 19 <u>56</u> that I last saw the deceased alive on <u>12 Jan.</u> 19 <u>56</u> and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. J. Jernell</u>		M.D. <u>652 W. Main</u>		ADDRESS (Street, city, town, or county) <u>Salisbury Md.</u>		DATE SIGNED <u>12 Jan 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>1-12-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cape Charles Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cape Charles, Northampton Co. Va.</u>	
24. REC'D BY REGISTRAR <u>Mary E. Salway</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Funeral Home</u> ADDRESS <u>Mary H. Stewart, 324 E Church St, Salisbury, Md.</u>			



1193

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Licamier</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Somerset</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Salisbury</i>				TOWN <i>Barnesley</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Peninsula General Hospital</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Catherine Bonner Sutphin</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>January 5 1956</i>			
5. SEX <i>Female</i>	6. CO. OR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Oct. 2, 1890</i>	9. AGE last birthday <i>65</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>Keewardin, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Florian J. Bonner</i>				14. MOTHER'S MAIDEN NAME <i>Clara E. Schnaiz</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes - War I.</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. William Sutphin</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>Coronary Artery Thrombosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Jan. 1, 1956</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Coronary Atherosclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <i>Cerebral Thrombosis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan. 22, 1955</i> to <i>Jan. 5, 1956</i> , that I last saw the deceased alive on <i>Jan. 5, 1956</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.							
SIGNATURE <i>David F. Sibore</i> M.D.				ADDRESS (Street, city, town, state) <i>Salisbury Md.</i> DATE SIGNED <i>Jan. 5, 1956</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Jan. 9, 1956</i>		NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		LOCATION (City, town, or county) (State) <i>Arlington, Va.</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary W. Holliman</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Leven R. Wilson</i>		ADDRESS <i>P. Anne, Ind.</i>	
DATE <i>1-7-56</i>							

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

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Reg. Dist. No. 332

1194

INSTRUCTIONS

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Wicomico</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Talbot</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Salisbury</u>	LENGTH OF STAY (in this place) <u>3 1/2 months</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Royal Oak</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Deer's Head State Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>William</u>	(Middle) <u>Edward</u>	(Last) <u>Thomas</u>	(Month) <u>1</u> (Day) <u>17</u> (Year) <u>19 56</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>12/25/1873</u>
9. AGE last birthday <u>77</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>James Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Thomas</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS <u>Hospital Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Recurrent cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>25 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis, general</u>		?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Very recent arteriosclerotic cardiovascular disease</u>		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)	
20c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
20d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		20e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept. 22, 1955</u> , to <u>Jan. 17, 1956</u> , that I last saw the deceased alive on <u>Jan. 16, 1956</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dr. V. J. Herman</u>		ADDRESS (Street, city, town, state) <u>V. J. Herman, M.D., Deer's Head Hospital, Salisbury, Md.</u>	
DATE SIGNED <u>1/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 20, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u>		LOCATION (City, town, or county) <u>Easton, Maryland</u>	
24. REC'D BY REGISTRAR <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Williams</u>	
DATE <u>1-23-56</u>		ADDRESS <u>266</u>	

RECEIVED

25 1956

BUREAU OF

MARYLAND

1195

CERTIFICATE OF DEATH

01178
STATE DEPARTMENT OF HEALTH

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Wicomico</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
TOWN <u>Salisbury</u>		TOWN <u>Salisbury</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>D. S. Hospital</u>		STREET ADDRESS (If rural, give location) <u>Salisbury</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Dannie</u> (Middle) <u>J.</u> (Last) <u>Twitt</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>June 1-1954</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>17</u> yrs. If under 1 year: Months <u>17</u> Days <u>18</u> Hours <u>18</u> Min. <u>18</u>
11. FATHER'S NAME <u>William J. Twitt</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. MOTHER'S MAIDEN NAME <u>Virginia S. Beady</u>		14. MOTHER'S MAIDEN NAME <u>Virginia S. Beady</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT AND ADDRESS <u>M. William J. Twitt, Salisbury md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
Immediate cause (a) <u>Acute Enteritis + dehydration</u>	Antecedent cause(s) (b).....	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-17-56 19....., to 1-18-56, 19....., that I last saw the deceasedalive on 1-18-56 19....., and that death occurred at..... 7 P. m., from the causes and on the date stated above.SIGNATURE Robert L. Palmer MD ADDRESS Snout Hill DATE SIGNED 1-20-56

23. BURIAL CREMATION REMOVAL (Specify) <u>Cremation</u>	DATE <u>Jan 22/56</u>	NAME OF CEMETERY OR CREMATORY <u>Snout Hill</u>	LOCATION (City, town, or county) <u>Salisbury md</u>
DATE REC'D BY LOCAL REG. <u>Jan 21, 56</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>	24. FUNERAL DIRECTOR <u>Wm. J. Twitt</u>	ADDRESS <u>Salisbury md</u>

MARGIN RESERVED FOR BINDING

12

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1196

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>		<u>3</u>		TOWN <u>POWELLVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GENERAL HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>KATE DELLA TRUITT</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JANUARY 24 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAR. 13 1885</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>HOMG</u>	11. BIRTHPLACE (State or foreign country) <u>POWELLVILLE MD</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES TRUITT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA WOOD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT & ADDRESS <u>MRS. SADIE DENNIS SALISBURY</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Chronic Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Undernutrition</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Chronic Thrombosis</u>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1956</u> to <u>1956</u> , that I last saw the deceased alive on <u>5-31-56</u> , and that death occurred at <u>5:35</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Mary W. Holloway</u>				ADDRESS (Street, city, town, state) <u>2200 W. ...</u> DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>1/20/56</u>	NAME OF CEMETERY OR CREMATORY <u>TRUITT</u>		LOCATION (City, town, or county) <u>POWELLVILLE MD</u>		(State)	
24. REC'D BY REGISTRAR <u>1-27-56</u>	REGISTRAR'S SIGNATURE <u>Mary W. Holloway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Buehler</u>		ADDRESS <u>Burlinghol</u>		

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INSTRUCTIONS

1. TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01180

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Wicomico</u> MARYLAND CITY OR TOWN <u>Salisbury</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Hill Sanitarium</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Delaware</u> COUNTY <u>Sussex</u> CITY OR TOWN <u>Delmar</u> STREET ADDRESS <u>RFD #2, Salisbury, Maryland</u>			
3. NAME OF DECEASED (Type or Print) <u>Sallie</u> (First) <u>Blon</u> (Middle) <u>West</u> (Last)		4. DATE OF DEATH <u>Jan. 24</u> (Month) <u>19</u> (Year) <u>56</u>		5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u> (Specify)		8. DATE OF BIRTH <u>Nov. 18, 1884</u>		9. AGE last birthday <u>71</u> yrs		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Laurel, Del.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Theodore Sirman</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Callaway</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Carl C. West, Delmar, Del.</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE (A) <u>Cardiovascular Renal Failure</u> ANTECEDENT CAUSE(S) DUE TO (B) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____				19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH _____			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 24, 1956</u> , to <u>Jan 24, 1956</u> , that I last saw the deceased alive on <u>Jan 24, 1956</u> , and that death occurred at <u>Salisbury, Del.</u> M, from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> M.D. ADDRESS (Street, city, town, state) <u>Salisbury, Del.</u> DATE SIGNED <u>1-25-56</u>							
23. BURIAL, CREATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 26-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laurel, Hill</u>		LOCATION (City, town, or county) (State) <u>Laurel, Del.</u>	
24. REC'D BY REGISTRAR <u>Jan. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Mary J. Hollaway</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

U. S. A. 100-100

100-100

100-100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Royer, Earl (Med Exam)

1198

01181
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Wicomico		STATE	Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN	Salisbury		TOWN	Salisbury	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	208 Race Street		STREET ADDRESS	(If rural, give location) 208 Race St.	
3. NAME OF DECEASED:	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
(Type or Print)	William	David	Williams	January	11 1956
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.
M	White	Married	July 29, 1885	70 yrs.	Months 5 Days 12 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?	
Truck Driver	Employee (Shoreland Freezer Co.)		Trenton, N. Carolina	USA	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Solomon Williams			Nancy (Unk)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:		
Unk (service)			Mrs. Ida L. Williams (Wife) 208 Race St Salisbury, Maryland		

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			Sudden
420.1 Immediate cause (a) Coronary Occlusion DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 1-11-56 M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Jan. 14, 1956	Parsons Cemetery	Salisbury, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
1-12-56	Mary W. Holloway	HOLLOWAY & COMPANY SALISBURY MARYLAND	

BUREAU V. S.

JAN 16 1962

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01182

1199

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>SOMERSET.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SALISBURY</u>				TOWN <u>PRINCESS ANNE</u> <u>194-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PENINSULA GEN HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>LAND AVE.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>HARRY</u> (Middle) <u>H.</u> (Last) <u>WILSON</u>				(Month) <u>JANUARY</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>MALE</u>	<u>White</u>	<u>Married</u>	<u>Aug. 23 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Chicken grower poultry</u>		<u>Maryland</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles L. Wilson</u>				<u>Julia Shores</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<u>No</u>		<u>212-16-1076</u>		<u>Mr. Ella Priddy Priddy</u>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>Myocardial Infarct, acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO (C)							
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
21a. DATE OF OPERATION				21b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-20</u>, 19<u>56</u>, to <u>1-27</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1-26</u>, 19<u>56</u>, and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>W. Bellis, Jr.</u>				<u>Salisbury, Md.</u>		<u>1-27-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>1-29-56</u>		<u>St. Andrew's Cem.</u>		<u>Princess Anne Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>1-30-56</u>		<u>Mary D. Holloway</u>		<u>Lee R. Wilson</u>		<u>Princess Anne Md.</u>	

CERTIFICATE OF DEATH

Date of Death

Place of Death

Age

Sex

Color

Marital Status

Occupation

BUREAU V. S.

FEB 1 1956

RECEIVED

DICTIONARY

NOT FOR PUBLICATION